

**GENITAL TRACT INFECTIONS****Epididymitis +/- Orchitis**

Pain and swelling of the epididymis +/- testis (orchitis), pyrexia, with or without urethral discharge.

**Organisms:**

- Sexually transmitted pathogens, e.g., [C. trachomatis](#), [N. gonorrhoeae](#)
- Enteric organisms associated with lower urinary tract infection (UTI), e.g., E. coli.
- In non-immunised, [mumps](#) virus

**Practice points:**

- **EXCLUDE TESTICULAR TORSION in ALL cases of pain and/or swelling of the epididymis or testis.**
- Consider [mumps orchitis](#) if there is a history of headache, fever or parotid swelling 7-10 days prior to testicular swelling. Scrotal involvement can occur in the absence of any systemic symptoms of mumps.
  - Send an inside cheek/throat viral swab for mumps PCR testing.
  - **Mumps is a notifiable disease**
- A detailed sexual history is required in all cases:
  - a) Epididymo-orchitis most probably due to any sexually transmitted infection (STI): younger patient, high-risk sexual history (new sexual partner or multiple recent sexual partners, lack of consistent condom use), contact of an STI, no previous urological procedure or UTI, urethral discharge present, urine dipstick positive for leucocytes only.
  - b) Epididymitis most likely caused by STI, and enteric organisms associated with lower UTI: STI risk factors in men who practice insertive anal sex.
  - c) Epididymo-orchitis most probably due to enteric organisms associated with lower UTI: e.g., an older patient, not sexually active, recent procedure and instrumentation (such as prostatic biopsy, vasectomy or catheterisation), and men who practice insertive anal intercourse, men with known abnormalities of the urinary tract, no urethral discharge, or positive urine dipstick for leucocytes and nitrites.
    - However, there is overlap between these groups, dependent on sexual history.
- Advise patient to abstain from sexual contact until they and any partner(s) have completed treatment. (Note: partner treatment may not be required in non-STI causes)
- Follow-up if there is a confirmed or suspected STI after 2 weeks. Check sexual abstinence and ensure partner notification is complete.
- Symptoms should be improving after 3 days.
- If microbiology results are positive for STI – refer to ISHS for follow-up and partner notification
- Check MSU and laboratory results and adjust antibiotics where necessary

**Investigations:**

- ❖ **IN-HOURS (DAYTIME):** Do NOT initiate antibiotic treatment and [contact the Integrated Sexual Health Service \(ISHS\)](#) for a same-day appointment if STI is likely.
  - ❖ **OUT of HOURS: FIRST,** take the following specimens and **then** treat [empirically](#) until the results are available. If STI is suspected, contact all sexual partners for treatment and follow-up by ISHS.
1. First-pass urine (FPU) flow for *C. trachomatis*, *N. gonorrhoeae*, and *M. genitalium* nucleic acid amplification tests (NAAT)
  2. Urine dipstick test and mid-stream urine (MSU) sample for “cell count, culture & sensitivity (MC&S).”
  3. If there is visible urethral discharge, take a urethral swab for *N. gonorrhoeae* MC&S. Do not place charcoal swabs within the urethra.

**Empirical Treatment****Patient information leaflet:**

- The MHRA patient leaflet on [Fluoroquinolone antibiotics: what you need to know about side effects of tendons, muscles, joints, and nerves.](#)
- The British Association for Sexual Health and HIV (BASHH) patient leaflet: [Epididymo-orchitis.](#)
- Patient.info patient leaflet: [Epididymo-orchitis](#)

**Central Booking Line numbers for Nottingham / Nottinghamshire Sexual Health Service**

<u>Mid-Notts:</u>	<b>My Sexual Health</b>	01623 672 260
<u>North Notts:</u>	<b>Tri Health</b>	01909 571 571 / 01777 200 177
<u>South Notts / Nottingham:</u>	<b>Nottingham Sexual Health</b>	0115 962 7627

## Empirical Treatment for Out of Hours

Medicine	Dose	Treatment duration
<b>If likely due to STI:</b>		
<b>First line:</b> Ceftriaxone <sup>1,2</sup> <b>Plus</b> Doxycycline	1 g IM  100mg orally twice daily	Single dose  14 days
<b>Second line:</b> (if a cephalosporin and/or tetracycline antibiotic is contraindicated.) Ofloxacin <sup>3</sup>	200mg orally twice daily	14 days
<b>If likely due to STI and enteric organisms associated with lower UTI:</b>		
Ceftriaxone <sup>1,2</sup> <b>Plus</b> Ofloxacin <sup>3</sup>	1 g IM  200mg orally twice daily	Single dose  14 days
<b>If likely due to enteric organisms associated with lower UTI:</b>		
<b>First line:</b> Ofloxacin <sup>3</sup> <b>or</b> Levofloxacin <sup>3</sup>	200mg orally twice daily  500mg orally once daily	14 days  10 days
<b>Second line:</b> (if quinolones are contraindicated.) Co-amoxiclav <sup>2,4</sup>	625mg orally three times daily	10 days

<sup>1</sup> Add 1 ml lidocaine 1% to each 250mg vial and give by deep IM injection only.

<sup>2</sup> Discuss with micro or ISHS if the patient has a severe penicillin allergy (anaphylaxis, angioedema or urticarial rash within the first 72 hours or allergy to cephalosporins).

<sup>3</sup> See fluoroquinolone antibiotics advice on [aortic aneurysms](#), [heart valve regurgitation](#), [musculoskeletal and nervous system](#).

<sup>4</sup> Review the urine culture results to determine if co-amoxiclav is still the appropriate antibiotic choice due to the increased local resistance rate of E. coli isolates in the community.

## Pre-pubertal child with Suspected Epididymo-orchitis

- Arrange emergency hospital admission if symptoms are severe (child is systemically unwell, or there is a suspected serious complication).
- Consider the diagnosis of [mumps orchitis](#). See [Mumps](#).
- Arrange a urine dipstick test and MSU sample for microscopy and culture. See [UTI in children](#) for management. Arrange onward referral to a paediatrician as appropriate.
- If UTI is not confirmed, do not start antibiotic treatment routinely
  - Reassure parents/carers that epididymitis is usually a self-limiting condition which resolves with rest and analgesia.
  - If there is any uncertainty about management, seek specialist advice or consider arranging a referral to paediatric urology—the urgency depends on clinical judgement.

Version Control- Epididymitis with or without orchitis			
Version	Author(s)	Date	Changes
V2.0	Shary Walker, Interface and Formulary Pharmacist	March 2023	<ul style="list-style-type: none"> <li>• Added the signs and symptoms. Pathogens linked to specific APC guidelines. MUMPs linked to NICE CKS – retained non-immunised. Highlighted “exclude testicular torsion in all cases.”</li> <li>• Enumerated likely causes of Epididymo-orchitis with examples and added corresponding empirical OOH treatment table.</li> <li>• Sexual abstinence advice, information on follow-up, and ISHS Contact information added</li> <li>• Investigations – daytime and OOH, including laboratory investigations added</li> <li>• Added an information summary of the NICE CKS – a pre-pubertal child with suspected Epididymo-orchitis</li> <li>• References: Guideline for the treatment of UTI in adults (NUH, Aug 2022), <a href="#">NICE CKS 2022</a>, <a href="#">BASHH 2020</a>.</li> </ul>